FAMILY SMILES OF FLEMING ISLAND

Patient Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

1. Before treatment is performed, we will discuss treatment and financial options. This will help you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.
2. Payment is due at the time service is provided.
3. Treatment Plans may change, but you are responsible for the work actually done.
4. Lab fees associated with your treatment are due prior to our submitting the case to the dental lab.
5. Our office accepts:

- Cash
- Personal Checks (Additional fees will be applied for returned checks)
- Visa, MasterCard, Discover, and American Express
- Third-party financing such as CareCredit is available upon request and approval

6. All account balances over 90-days are subject to a $35.00 late fee.
7. If sent to Collections due to non-payment, you will be responsible for related fees and court costs.

DENTAL INSURANCE: As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are your responsibility. Please contact your insurance company for details of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons specifically related to your plan.

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you as our patient and not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form allows us to release your treatment information to your insurance company and instructs your insurance company to make payment directly to our office.

By signing this "Patient Financial Policy," you authorize the release of any information concerning your (or your child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

- We ask that you pay the deductible, co-payment, and co-insurance which is the estimated amount not covered by your dental insurance company at the time we provide the service to you.

• Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact them to make sure payment is being processed. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

• We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

EMERGENCY CLIENTS: Emergency clients that are new to our practice are expected to make payment at the time of service.

MINORS ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN: The parent or legal guardian whether accompanying a minor or not, who has consented to treatment, is responsible for full payment at the time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

MISSED APPOINTMENT(S) & CANCELLATIONS: Our goal is to provide treatment in a timely manner with as few visits as necessary. To provide the best services to our patients, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

CONSENT: I have read, understand, and agree to the above terms and conditions. I authorize my dental insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine and due at the time services are rendered.

COMMUNICATIONS WITH YOU: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient First & Last Name:_____ Birthdate:_____

Signature:_____ Date:_____